



2021-22 ANNUAL PREPARTICIPATION PHYSICAL EVALUATION

(The parent or guardian should fill out this form with assistance from the student-athlete) Exam Date: _____

| | |
|---|--|
| <p>Name: _____</p> <p>Home Address: _____</p> <p>Phone: _____</p> <p>Date of Birth: _____</p> <p>Age: _____</p> <p>Gender: _____</p> <p>Grade: _____</p> <p>School: _____</p> <p>Sport(s): _____</p> <p>Personal Physician: _____</p> <p>Hospital Preference: _____</p> | <p>In case of emergency contact:</p> <p>Name: _____</p> <p>Relationship: _____</p> <p>Phone (Home): _____</p> <p>Phone (Work): _____</p> <p>Phone (Cell): _____</p> <hr style="border-top: 1px dashed black;"/> <p>Name: _____</p> <p>Relationship: _____</p> <p>Phone (Home): _____</p> <p>Phone (Work): _____</p> <p>Phone (Cell): _____</p> |
|---|--|

Explain "Yes" answers on the following page.
Circle questions you don't know the answers to.

| | Y | N |
|--|--------------------------|--------------------------|
| 1) Has a doctor ever denied or restricted your participation in sports for any reason? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2) Do you have an ongoing medical conditional (like diabetes or asthma)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3) Are you currently taking any prescription or nonprescription (over-the-counter) medicines or supplements? (Please specify): _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 4) Do you have allergies to medicines, pollens, foods or stringing insects? (Please specify): _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 5) Does your heart race or skip beats during exercise? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6) Has a doctor ever told you that you have (check all that apply): <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> A Heart Murmur <input type="checkbox"/> High Cholesterol <input type="checkbox"/> A Heart Infection | | |
| 7) Have you ever spent the night in a hospital? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8) Have you ever had surgery? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9) Have you ever had an injury (sprain, muscle/ligament tear, tendinitis, etc.) that caused you to miss a practice or game? (If yes, check affected area in the box below in question 11) | <input type="checkbox"/> | <input type="checkbox"/> |
| 10) Have you had any broken/fractured bones or dislocated joints? (If yes, check affected area in the box below in question 11): | <input type="checkbox"/> | <input type="checkbox"/> |
| 11) Have you had a bone/joint injury that required X-rays, MRI, CT, surgery, injections, rehabilitation physical therapy, a brace, a cast or crutches? (If yes, check affected area in the box below): | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Head <input type="checkbox"/> Neck <input type="checkbox"/> Shoulder <input type="checkbox"/> Upper Arm <input type="checkbox"/> Elbow <input type="checkbox"/> Forearm <input type="checkbox"/> Hand/Fingers <input type="checkbox"/> Chest <input type="checkbox"/> Upper Back <input type="checkbox"/> Lower Back <input type="checkbox"/> Hip <input type="checkbox"/> Thigh <input type="checkbox"/> Knee <input type="checkbox"/> Calf/Shin <input type="checkbox"/> Ankle <input type="checkbox"/> Foot/Toes | | |

| | Y | N |
|---|--------------------------|--------------------------|
| 12) Have you ever had a stress fracture? | <input type="checkbox"/> | <input type="checkbox"/> |
| 13) Have you ever been told that you have, or have you had an X-ray for atlantoaxial (neck) instability? | <input type="checkbox"/> | <input type="checkbox"/> |
| 14) Do you regularly use a brace or assistive device? | <input type="checkbox"/> | <input type="checkbox"/> |
| 15) Has a doctor told you that you have asthma or allergies? | <input type="checkbox"/> | <input type="checkbox"/> |
| 16) Do you cough, wheeze or have difficulty breathing during or after exercise? | <input type="checkbox"/> | <input type="checkbox"/> |
| 17) Is there anyone in your family who has asthma? | <input type="checkbox"/> | <input type="checkbox"/> |
| 18) Have you ever used an inhaler or taken asthma medication? | <input type="checkbox"/> | <input type="checkbox"/> |
| 19) Were you born without, are you missing, or do you have a nonfunctioning kidney, eye, testicle or any other organ? | <input type="checkbox"/> | <input type="checkbox"/> |
| 20) Have you had infectious mononucleosis (mono) within the last month? | <input type="checkbox"/> | <input type="checkbox"/> |
| 21) Do you have any rashes, pressure sores or other skin problems? | <input type="checkbox"/> | <input type="checkbox"/> |
| 22) Have you had a herpes skin infection? | <input type="checkbox"/> | <input type="checkbox"/> |
| 23) Have you ever had an injury to your face, head, skull or brain (including a concussion, confusion, memory loss or headache from a hit to your head, having your "bell rung" or getting "dinged")? | <input type="checkbox"/> | <input type="checkbox"/> |
| 24) Have you ever had a seizure? | <input type="checkbox"/> | <input type="checkbox"/> |
| 25) Have you ever had numbness, tingling or weakness in your arms or legs after being hit, falling, stingers or burners? | <input type="checkbox"/> | <input type="checkbox"/> |
| 26) While exercising in the heat, do you have severe muscle cramps or become ill? | <input type="checkbox"/> | <input type="checkbox"/> |
| 27) Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease? | <input type="checkbox"/> | <input type="checkbox"/> |
| 28) Have you ever been tested for sickle cell trait? | <input type="checkbox"/> | <input type="checkbox"/> |
| 29) Have you had any problems with your eyes or vision? | <input type="checkbox"/> | <input type="checkbox"/> |
| 30) Do you wear glasses or contact lenses? | <input type="checkbox"/> | <input type="checkbox"/> |
| 31) Do you wear protective eyewear, such as goggles or a face shield? | <input type="checkbox"/> | <input type="checkbox"/> |
| 32) Are you happy with your weight? | <input type="checkbox"/> | <input type="checkbox"/> |
| 33) Are you trying to gain or lose weight? | <input type="checkbox"/> | <input type="checkbox"/> |
| 34) Has anyone recommended you change your weight or eating habits? | <input type="checkbox"/> | <input type="checkbox"/> |
| 35) Do you limit or carefully control what you eat? | <input type="checkbox"/> | <input type="checkbox"/> |
| 36) Do you have any concerns that you would like to discuss with a doctor? | <input type="checkbox"/> | <input type="checkbox"/> |

Females Only

Explain "Yes" Answers Here

| | Y | N |
|--|--------------------------|--------------------------|
| 37) Have you ever had a menstrual period? | <input type="checkbox"/> | <input type="checkbox"/> |
| 38) How old were you when you had your first menstrual period? | _____ | |
| 39) How many periods have you had in the last year? | _____ | |



2021-22 ANNUAL PREPARTICIPATION PHYSICAL EXAMINATION

The physician should fill out this form with assistance from the parent or guardian.)

Student Name: _____

Date of Birth: _____

Patient History Questions: Please Tell Me About Your Child...

- | | Y | N |
|---|--------------------------|--------------------------|
| 1) Has your child fainted or passed out DURING or AFTER exercise, emotion or startle? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2) Has your child ever had extreme shortness of breath during exercise? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3) Has your child had extreme fatigue associated with exercise (different from other children)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4) Has your child ever had discomfort, pain or pressure in his/her chest during exercise? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5) Has a doctor ever ordered a test for your child's heart? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6) Has your child ever been diagnosed with an unexplained seizure disorder? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7) Has your child ever been diagnosed with exercise-induced asthma not well controlled with medication? | <input type="checkbox"/> | <input type="checkbox"/> |

Explain "Yes" Answers Here

COVID-19...

- | | Y | N |
|--|--------------------------|--------------------------|
| 1) Has your child been diagnosed with COVID-19? | <input type="checkbox"/> | <input type="checkbox"/> |
| 1a) If yes, is your child still having symptoms from their COVID-19 infection? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2) Was your child hospitalized as a result for complications of COVID-19? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3) Has your child been diagnosed with Multi-Inflammatory Syndrome in Children (MIS-C)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4) Did your child have any special tests ordered for their heart or lungs or were referred to a heart specialist (cardiologist) to be cleared to return to sports? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5) Has your child returned back to full participation in sports? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6) Has your child had direct or known exposure to someone diagnosed with COVID-19 in the past 3 months? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6a) Was your child tested for COVID-19? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7) Did your child receive the COVID-19 vaccine? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7a) What was the manufacturer of the vaccine? _____ | | |
| 7b) Date of vaccination(s) _____ | | |

Explain "Yes" Answers Here



Family History Questions: Please Tell Me About Any Of The Following In Your Family...

| | Y | N | | Y | N |
|--|--------------------------|--------------------------|--|--------------------------|--------------------------|
| 1) Are there any family members who had sudden/unexpected/unexplained death before age 50? (including SIDS, car accidents drowning or near drowning) | <input type="checkbox"/> | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> |
| 2) Are there any family members who died suddenly of "heart problems" before age 50? | <input type="checkbox"/> | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> |
| 3) Are there any family members who have unexplained fainting or seizures? | <input type="checkbox"/> | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> |
| 4) Are there any relatives with certain conditions, such as: | | | | | |
| | Y | N | | Y | N |
| Enlarged Heart | <input type="checkbox"/> | <input type="checkbox"/> | Catecholaminergic Polymorphic Ventricular Tachycardia (CPVT) | <input type="checkbox"/> | <input type="checkbox"/> |
| Hypertrophic Cardiomyopathy (HCM) | <input type="checkbox"/> | <input type="checkbox"/> | Arrhythmogenic Right Ventricular Cardiomyopathy (ARVC) | <input type="checkbox"/> | <input type="checkbox"/> |
| Dilated Cardiomyopathy (DCM) | <input type="checkbox"/> | <input type="checkbox"/> | Marfan Syndrome (Aortic Rupture) | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart Rhythm Problems | <input type="checkbox"/> | <input type="checkbox"/> | Heart Attack, Age 50 or Younger | <input type="checkbox"/> | <input type="checkbox"/> |
| Long QT Syndrome (LQTS) | <input type="checkbox"/> | <input type="checkbox"/> | Pacemaker or Implanted Defibrillator | <input type="checkbox"/> | <input type="checkbox"/> |
| Short QT Syndrome | <input type="checkbox"/> | <input type="checkbox"/> | Deaf at Birth | <input type="checkbox"/> | <input type="checkbox"/> |
| Brugada Syndrome | <input type="checkbox"/> | <input type="checkbox"/> | | | |

Explain "Yes" Answers Here

I hereby state that, to the best of my knowledge, my answers to all of the above questions are complete and correct. Furthermore, I acknowledge and understand that my eligibility may be revoked if I have not given truthful and accurate information in response to the above questions.

Signature of Student-Athlete Signature of Parent/Guardian Date

Signature of MD/DO/ND/NMD/NP/PA-C/CCSP Date



2021-22 ANNUAL PREPARTICIPATION PHYSICAL EXAMINATION

| | |
|---|--|
| Name: _____ | Date of Birth: _____ |
| Age: _____ | Sex: _____ |
| Height: _____ | Weight: _____ |
| % Body Fat (optional): _____ | Pulse: _____ |
| | BP: ____ / ____ (____ / ____ , ____ / ____) |
| Vision: R20/____ L20/____ | Corrected: Y <input type="radio"/> N <input type="radio"/> |
| Pupils: Equal <input type="radio"/> Unequal <input type="radio"/> | |

| | Normal | Abnormal Findings | Initials * |
|------------------------|--------|-------------------|------------|
| Medical | | | |
| Appearance | | | |
| Eyes/Ears/Throat/Nose | | | |
| Hearing | | | |
| Lymph Nodes | | | |
| Heart | | | |
| Murmurs | | | |
| Pulses | | | |
| Lungs | | | |
| Abdomen | | | |
| Genitourinary & | | | |
| Skin | | | |
| Musculoskeletal | | | |
| Neck | | | |
| Back | | | |
| Shoulder/Arm | | | |
| Elbow/Forearm | | | |
| Wrist/Hands/Fingers | | | |
| Hip/Thigh | | | |
| Knee | | | |
| Leg/Ankle | | | |
| Foot/Toes | | | |

* - Multi-examiner set-up only

& - Having a third party present is recommended for the genitourinary examination

NOTES:

☐ Cleared Without Restriction

☐ Cleared With Following Restriction: _____

☐ Not Cleared For: ☐ All Sports ☐ Certain Sports: _____ Reason: _____

Recommendations: _____

Name of Physician (Print/Type): _____ Exam Date: _____

Address: _____ Phone: _____

Signature of Physician: _____, MD/DO/ND/NMD/NP/PA-C/CCSP

Arizona Interscholastic Association, Inc.
Mild Traumatic Brain Injury (MTBI) / Concussion
Annual Statement and Acknowledgement Form

I, _____ (student), acknowledge that I have to be an active participant in my own health and have the direct responsibility for reporting all of my injuries and illnesses to the school staff (e.g., coaches, team physicians, athletic training staff). I further recognize that my physical condition is dependent upon providing an accurate medical history and a full disclosure of any symptoms, complaints, prior injuries and/or disabilities experienced before, during or after athletic activities.

By signing below, I acknowledge:

- My institution has provided me with specific educational materials including the CDC Concussion fact sheet (<http://www.cdc.gov/concussion/HeadsUp/youth.html>) on what a concussion is and has given me an opportunity to ask questions.
- I have fully disclosed to the staff any prior medical conditions and will also disclose any future conditions.
- There is a possibility that participation in my sport may result in a head injury and/or concussion. In rare cases, these concussions can cause permanent brain damage, and even death.
- A concussion is a brain injury, which I am responsible for reporting to the team physician or athletic trainer.
- A concussion can affect my ability to perform everyday activities, and affect my reaction time, balance, sleep, and classroom performance.
- Some of the symptoms of concussion may be noticed right away while other symptoms can show up hours or days after the injury.
- If I suspect a teammate has a concussion, I am responsible for reporting the injury to the school staff.
- I will not return to play in a game or practice if I have received a blow to the head or body that results in concussion related symptoms.
- I will not return to play in a game or practice until my symptoms have resolved AND I have written clearance to do so by a qualified health care professional.
- Following concussion the brain needs time to heal and you are much more likely to have a repeat concussion or further damage if you return to play before your symptoms resolve.

Based on the incidence of concussion as published by the CDC the following sports have been identified as high risk for concussion; baseball, basketball, diving, football, pole vaulting, soccer, softball, spiritline and wrestling.

I represent and certify that I and my parent/guardian have read the entirety of this document and fully understand the contents, consequences and implications of signing this document and that I agree to be bound by this document.

Student Athlete:

Print Name: _____ Signature: _____ Date: _____

Parent or legal guardian must print and sign name below and indicate date signed:

Print Name: _____ Signature: _____ Date: _____



2021-22 CONSENT TO TREAT FORM

Parental consent for minor athletes is generally required for sports medicine services, defined as services including, but not limited to, evaluation, diagnosis, first aid and emergency care, stabilization, treatment, rehabilitation and referral of injuries and illnesses, along with decisions on return to play after injury or illness. Occasionally, those minor athletes require sports medicine services before, during and after their participation in sport-related activities, and under circumstances in which a parent or legal guardian is not immediately available to provide consent pertaining to the specific condition affecting the athlete. In such instances it may be imperative to the health and safety of those athletes that sports medicine services necessary to prevent harm be provided immediately, and not be withheld or delayed because of problems obtaining consent of a parent/guardian.

Accordingly, as a member of the Arizona Interscholastic Association (AIA), _____ (name of school or district) requires as a pre-condition of participation in interscholastic activities, that a parent/guardian provide written consent to the rendering of necessary sports medicine services to their minor athlete by a qualified medical provider (QMP) employed or otherwise designated by the school/district/AIA, to the extent the QMP deems necessary to prevent harm to the student-athlete. It is understood that a QMP may be an athletic trainer, physician, physician assistant or nurse practitioner licensed by the state of Arizona (or the state in which the student-athlete is located at the time the injury/illness occurs), and who is acting in accordance with the scope of practice under their designated state license and any other requirement imposed by Arizona law. In emergency situations, the QMP may also be a certified paramedic or emergency medical technician, but only for the purpose of providing emergency care and transport as designated by state regulation and standing protocols, and not for the purpose of making decisions about return to play.

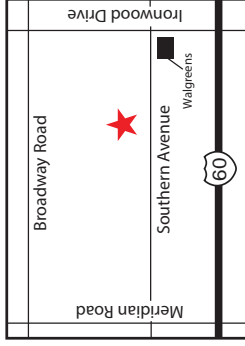
PLEASE PRINT LEGIBLY OR TYPE

"I, _____, the undersigned, am the parent/legal guardian of, _____, a minor and student-athlete at _____ (name of school or district) who intends to participate in interscholastic sports and/or activities.

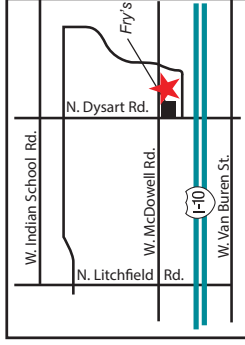
I understand that the school/district/AIA employs or designates QMP's (as defined above) to provide sports medicine services (as also defined above) to the school's interscholastic athletes before, during or after sport-related activities, and that on certain occasions there are sport-related activities conducted away from the school/district facilities during which other QMP's are responsible for providing such sports medicine services. I hereby give consent to any such QMP to provide any such sports medicine services to the above-named minor. The QMP may make decisions on return to play in accordance with the defined scope of practice under the designated state license, except as otherwise limited by Arizona law. I also understand that documentation pertaining to any sports medicine services provided to the above-named minor, may be maintained by the QMP. I hereby authorize the QMP who provides such services to the above-named minor to disclose such information about the athlete's injury/illness, assessment, condition, treatment, rehabilitation and return to play status to those who, in the professional judgment of the QMP, are required to have such information in order to assure optimum treatment for and recovery from the injury/illness, and to protect the health and safety of the minor. I understand such disclosures may be made to above-named minor's coaches, athletic director, school nurse, any classroom teacher required to provide academic accommodation to assure the student-athlete's recovery and safe return to activity, and any treating QMP.

If the parent believes that the minor is in need of further treatment or rehabilitation services for the injury/illness, the minor may be treated by the physician or provider of his/her choice. I understand, however, that all decisions regarding same day return to activity following injury/illness shall be made by the QMP employed/designated by the school/district/AIA.

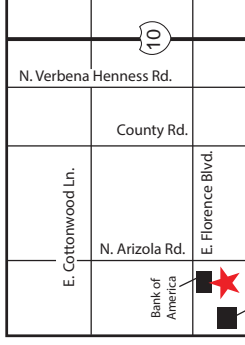
Date: _____ Signature: _____



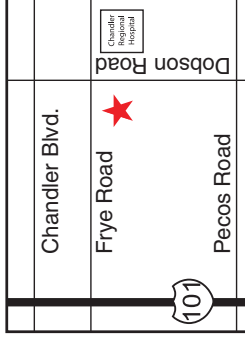
Apache Junction • 85120
2080 West Southern Ave., Suite #A1



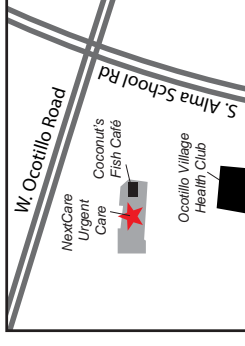
Avondale • 85392
13075 W. McDowell Rd., Suite #D106



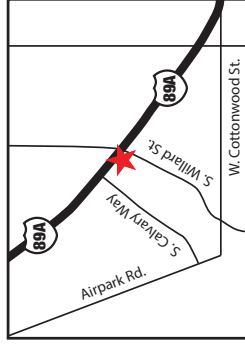
Casa Grande • 85122
1683 E. Florence Blvd., Suite #7



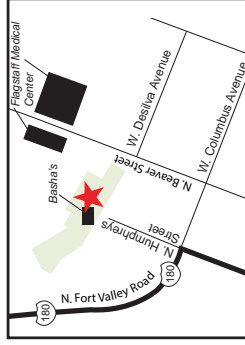
Chandler • 85224
600 S. Dobson Road, Suite #C-26



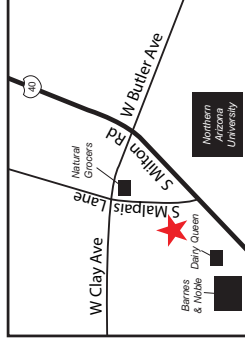
Chandler • 85248
1155 W. Ocotillo Road, Suite #4



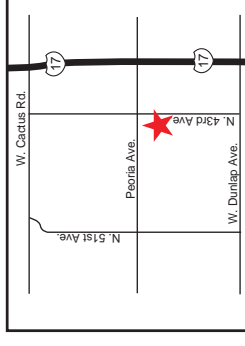
Cottonwood • 86326
450 S. Willard Street, Suite #120



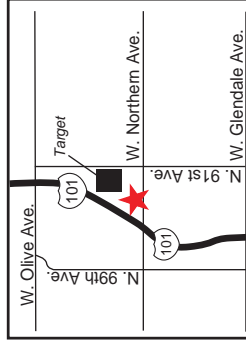
Flagstaff • 86001
1000 N. Humphreys St., Suite #104



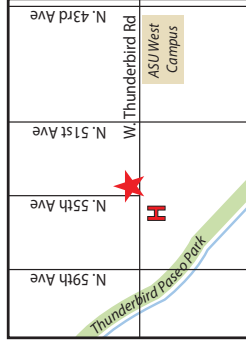
Flagstaff • 86001
399 S. Malpais Lane, Suite #100



Glendale • 85302
10240 N. 43rd Ave., Suite #3



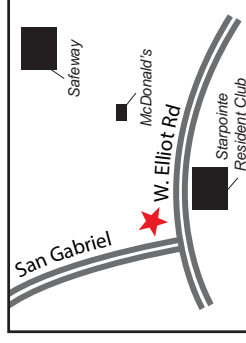
Glendale • 85305
9494 W. Northern Ave., Suite #101



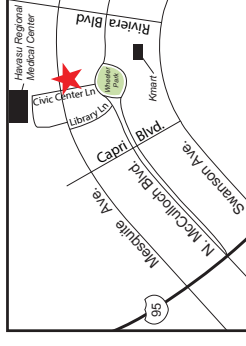
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5410 W. Thunderbird Road, Suite #101



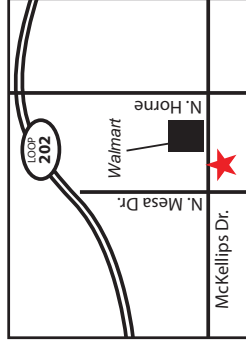
Glendale • 85308
18589 N. 59th Ave., Suite #101



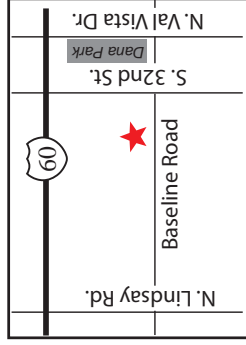
Goodyear • 85338
17688 W. Elliot Road



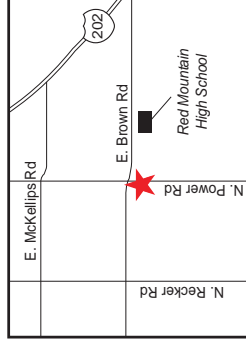
Lake Havasu City • 86403
1810 Mesquite Ave., Suite B



Mesa • 85203
535 E. McKellips Road, Suite #101



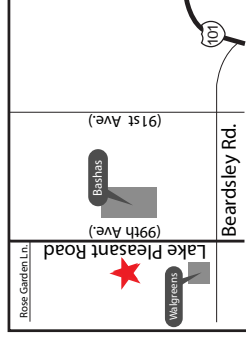
Mesa • 85204
3130 E. Baseline Road, Suite #105



Mesa • 85205
1066 N. Power Road, Suite #101



Nogales • 85621
298 W. Mariposa Road

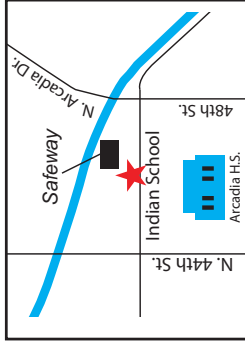


Peoria • 85382
20470 N. Lake Pleasant Rd., Suite #102



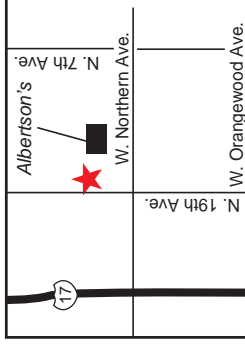
Phoenix • 85016

1701 E. Thomas Road, Suite #A104



Phoenix • 85018

4730 E. Indian School Rd., Suite #211



Phoenix • 85021

8101 N. 19th Ave., Suite #A



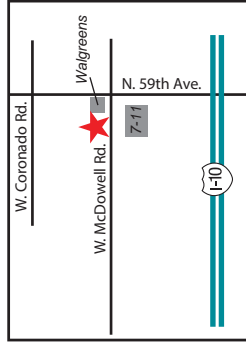
Phoenix • 85032

3229 E. Greenway Rd., Suite #102



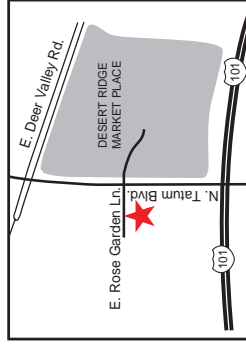
Phoenix • 85018

3931 E. Camelback Road



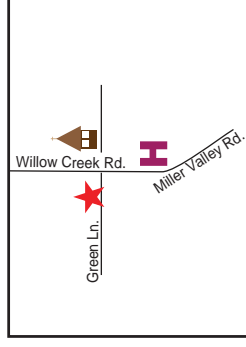
Phoenix • 85035

5920 W. McDowell Road



Phoenix • 85050

20950 N. Tatum Blvd., Suite #190



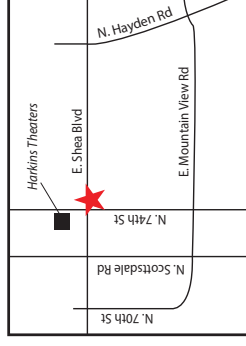
Prescott • 86301

2062 Willow Creek Road



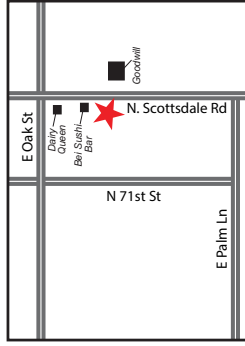
Prescott Valley • 86314

3051 N. Windsong Drive



Scottsdale • 85260

7425 E. Shea Blvd., Suite #108



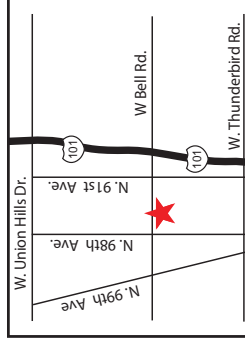
Scottsdale • 85257

2122 N. Scottsdale Road



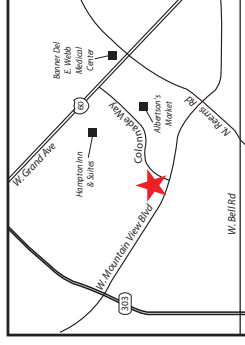
Sedona • 86336

2530 W. SR 89A, Suite #A



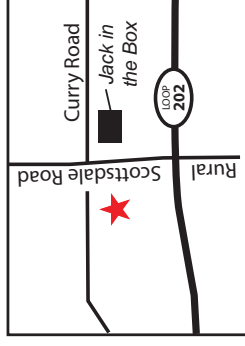
Sun City • 85351

9745 W. Bell Road, Suite #105



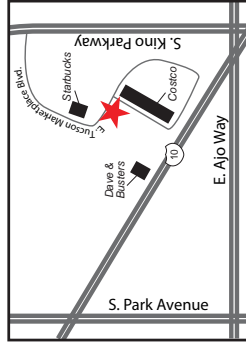
Surprise • 85374

14800 W. Mtn. View Blvd., Suite #100



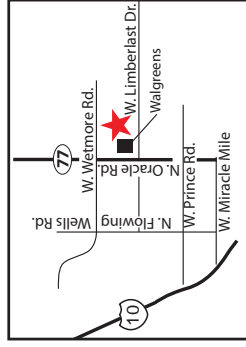
Tempe • 85281

914 N. Scottsdale Rd., Suite #104



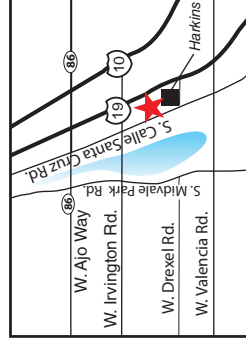
Tucson • 85713

1570 E. Tucson Marketplace Blvd.



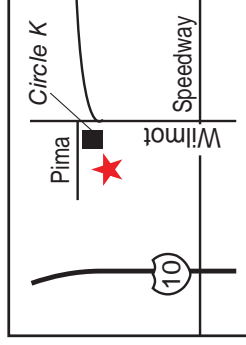
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4280 North Oracle Rd., Suite #100



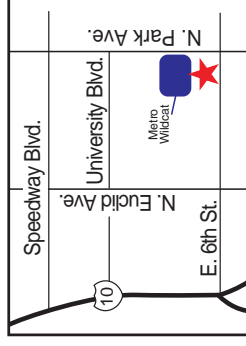
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6238 E. Pima Street

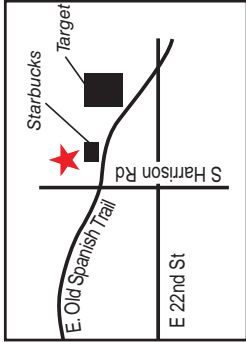


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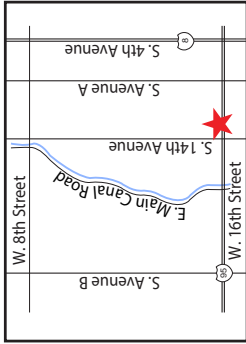
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